

## Early Intervention Program Referral Form

The form may be Faxed to CHAP at 206-263-5761 or you may phone them at 1-800-756-5437. Please indicate the feedback that you want to receive from the Early Intervention Program in response to your referral. Diagnosis of a specific condition or disorder is not necessary for a referral.

### Parent/Child Contact Information

Child Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Child Age: (months) \_\_\_\_ Gender: ☐ M ☐ F  
Home Address: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_  
Primary Language: \_\_\_\_\_ Needs Interpreter: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

### Reason(s) for Referral to Early Intervention

*(Please check all that apply)*

- ☐ Identified condition or diagnosis (e.g., spina bifida, Down syndrome): \_\_\_\_\_
- ☒ Suspected developmental delay or concern. **Please check areas of concern:**
- ☐ Motor/Physical ☐ Cognitive ☐ Social/Emotional ☐ Speech/Language ☐ Behavior ☐ Feeding
- ☐ Other (Describe): \_\_\_\_\_

### Referral Source Contact Information

Person Making Referral: \_\_\_\_\_ Date of Referral: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_  
Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_ Email: \_\_\_\_\_

### Early Intervention Program Contact Information

- ☐ I am referring the child named above to CHAP (King County Central Point of Entry) **OR**
- ☐ Directly to a provider agency. Please list agency name: \_\_\_\_\_
- Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

### Feedback Requested by the Referral Source

Date Referral Received: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Initial Appointment with Child/Family: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Name of Assigned Service Coordinator: \_\_\_\_\_  
Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_ Email: \_\_\_\_\_

*After initial appointment, please send the following information:*

- ☒ Status of Initial Family Contact ☐ Changes in Services Being Provided
- ☒ Developmental Evaluation Results ☐ Periodic Progress Reports/Summaries
- ☒ Services Being Provided to Child/Family ☐ Other (Describe): \_\_\_\_\_

### Release of Information Consent

I, \_\_\_\_\_ (Print name of parent or guardian), give my permission for my pediatric health care provider, \_\_\_\_\_ (print provider's name), to share any and all pertinent information regarding my child, \_\_\_\_\_ (print child's name), with the early intervention program(s) which will be screening or evaluating my child to determine eligibility for services or the development of an Individual Family Service Plan (IFSP).

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

This form was developed by the National Center of Medical Home Initiatives for Children with Special Needs and modified slightly for King County. To learn more about Medical Home Initiatives and Early Intervention go to <http://www.medicalhomeinfo.org/health/EI.html>. To utilize this form as a referral form and completing it electronically, you can find it on the following website: <http://kingcounty.gov/dchs/ddc/partners/earlyintervention/forms>.

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